

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

66828

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH: Calvert.
 County Prince Frederick, Md.
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? -----
 Hospital, institution, or street address where death occurred:
Calvert County Hospital, Prince Frederick, Md.
 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State WASHINGTON, D. C. County -----
 City or town WASHINGTON, D. C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. RECEIVING STATION, NAVY YARD
 (If rural, give LOCATION)
 2.(a) If veteran, name war WORLD WAR II ☒

3. (a) FULL NAME

Norris Harkness

3. (b) Social Security Number

Robert, Jr.

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced DIVORCED

6. (b) Name of husband or wife DIVORCED

7. Birth date of deceased (mo., day, yr.) July 26, 1919 8. (c) If alive, give age ----- years

8. AGE: Years 25 Months 11 Days 27 If less than one day ----- hrs. ----- min.

9. Birthplace Chicago, Illinois.
 (Town, county, and state)

10. Usual occupation U. S. Navy
Naval Service

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name unknown

15. Birthplace

16. Informant Hospital Records.

Address

17. removal Date thereof 7-26-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Geo. W. Wise Co. Inc.

Address

19. 7-26 19 45 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 July 19 45 at 8-45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 July 19 45 to 23 July 19 45 and that I last saw him alive on 23 July 19 45

Immediate cause of death

fracture of skull

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide yes Date of 23 Jul 45Where did injury occur? Cherry Corner Calvert, Md.
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) State Road

Means of injury

Injured at work?

23. SIGNATURE

Address Washington, Md. Data signed 23 July 45

M. D. or other

RECEIVED
AUG 7 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06829

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CalvertCity or town Tower Marlers Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Md County CalvertCity or town Tower Marlers
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(c) If veteran, name war

3. (a) FULL NAME

Arthur H. Freeland

3. (b) Social Security Number

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 12, 19348. AGE: Years 11 Months 4 Days 18 If less than one day
.....hrs.min.9. Birthplace Md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Arthur Freeland13. Birthplace Md14. Maiden name Carlie Howe15. Birthplace Md16. Informant Arthur FreelandAddress Tower Marlers17. Burial Date thereof 7-4-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory mt HopeLocation Calvert18. Funeral director P.E. SewellAddress Bruce Frederick19. July 3 19 45 J.M. King
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1/45 19 45 at 12:00 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death Stroke

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/1/45Where did injury occur? Tower Marlers Calvert
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Home

Means of injury Injured at work?

23. SIGNATURE Howard M. D. or otherAddress St. Mary's Md Date signed July 1945

RECEIVED
JUL 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH



06830

57

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Cabot
 City or town..... Near Solomons, Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Va County..... Arlington
 City or town..... N. Danville St.
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Jesse W. Harrington

3. (b) Social Security Number

7

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Annie Harrington
 7. Birth date of deceased (mo., day, yr.)..... Sept. 19, 1905 6.(c) If alive, give age..... 7 years
 8. AGE: Years..... 40 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Montross, Va
(Town, county, and state)10. Usual occupation..... Solomon

11. Industry or business

FATHER 12. Name..... E. C. Harrington
 13. Birthplace..... Va
 MOTHER 14. Maiden name..... Guarita Porter
 15. Birthplace..... Va

16. Informant..... E. T. Harrington
 Address..... N. Danville St.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof..... 7-14-45
 (month) (day) (year)

Cemetery or crematory..... Cedar Hill
 Location..... Suitland, Md

18. Funeral director..... A. A. Hackness & sons
 Address..... Mutual, Md

19. July 13, 45 (Date rec'd by registrar) 19 45 P. M. King Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 4 19 45 at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., 10....., 19.....
 and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

From

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... 7-4-45

Where did injury occur?..... Salisbury, Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Fell off boat Injured at work?.....

23. SIGNATURE.....

H. W. Ward
Dep. Med. Exam
 Address..... Salisbury, Md Date signed.....

M. D. or other

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JUL 17 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66831

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CalvertCity or town Lusby (Fly Pond)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CCCity or town 522 W St 4E
(If outside city or town limits, write RURAL and give nearest town)Street No. 5
(If rural, give LOCATION)2(a) If veteran, name war ✓

3. (a) FULL NAME

Edward F. Heplin

3. (b) Social Security Number

34. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced ?

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 10, 19228. AGE: 23 Years 7 Months 10 Days 1 If less than one day1922 hrs. 10 min.9. Birthplace Blueville Va
(Town, county, and state)10. Usual occupation ?11. Industry or business ?12. Name Ben Heplin13. Birthplace ?14. Maiden name Birdie Jacob.15. Birthplace ?16. Informant Ben HeplinAddress Wash DC17. Burial & Removal Date thereof July 4th 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friedrichsburg, VaLocation A. A. Neckers & Son18. Funeral director Mutual, IndAddress 7-419. 7-4 19 45 Registrar E. J. King

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 45 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death HeartDUE TO Found 245 PL 7/1/1945

DUE TO _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide President Date of July 1Where did injury occur? Core PT Club (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Ches. BayMeans of injury W Injured at work? W23. SIGNATURE H. J. KingM. D. or other Dr. J. E. KingAddress 7-4 Date signed 7/1/45

RECEIVED
JUL 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Cabot
 City or town Port Republic
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Cabot
 City or town Port Republic
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Edmund C. Johnson

3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced s

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1870 6. (c) If alive, give age _____ years

8. AGE: Years 74 Months 9 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Franklin N. Virginia
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business _____

12. Name John N. Johnson13. Birthplace West Virginia14. Maiden name Phoebe Simmons15. Birthplace West Virginia16. Informant Isidore SedwiczAddress Port Republic, Md

17. Removal Date thereof Aug 1, 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Huntingbury, IndianaLocation Indiana18. Funeral director A. P. Harkness & SonAddress Mutual, Md19. 8-1 19 45 J. N. King

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1942 to July 1945
 and that I last saw him alive on July 27, 1945

Immediate cause of death Generalized arteriosclerosis DURATION 2 or 3 years
Dementia senilis

Due to _____

Due to _____

Other conditions Congenital spasm

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Pyre C. J. King M. D. or other _____Address Port Republic, Md Date signed 8-1-45

RECEIVED

AUG 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-4

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:

County CabotCity or town Solomons
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph C. Love Sr.4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced M6. (b) Name of husband or wife Sarah Jane Love6. (c) If alive, give age 29 years7. Birth date of deceased (mo., day, yr.) May 30, 18638. AGE: Years 52 Months 1 Days 19 It less than one day

hrs. min.

9. Birthplace Newport N.J.
(Town, county, and state)10. Usual occupation Seaford Packer

11. Industry or business

12. Name Orick L. Love13. Birthplace N.J.14. Maiden name Amanda Osborn15. Birthplace N.J.16. Informant Rupert LoveAddress Solomons, Md17. Burial Date thereof July 22, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Solomons M.F.Location Solomons, Md18. Funeral director A. G. Wickens & sonAddress Wheat, Md19. 7/21 45 AYE S. Coster
(Date rec'd by registrar) (month) (day) (year) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CabotCity or town Solomons
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war no

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 19 45 at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 19 45 to 19and that I last saw him alive on 19Immediate cause of death acute Cardiac FailureDue to atheroscleroticheart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Page JettAddress James SolomonsDate signed 7/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4425

CERTIFICATE OF DEATH

16834

Reg. Dist. No. 214

1. PLACE OF DEATH:

County... Calvert County, Md.City or town... Currings, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:

Currings, Cal. Co. Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... CalvertCity or town... Currings

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 416

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edith Mary Lane

3. (b) Social Security Number

—

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife John Douglas Lane, Jr.March 15, 19146.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.)

March 24, 1916

8. AGE: Years Months Days If less than one day

29310

.....hrs.min.

9. Birthplace Silver Spring, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Lloyd Thomas Clark13. Birthplace Silver Spring, Md.14. Maiden name Helen Mary Schrieder15. Birthplace Silver Spring, Md.16. Informant John Douglas Lane, Jr.Address Currings, Cal. Co. Md.17. Burial Date thereof July 6, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Fort Lincoln CemeteryLocation Bladenburg Rd., Md.18. Funeral director Werner E. HumphreyAddress Silver Spring, Md.19. (Date rec'd by registrar) July 5, 1945Josephine M. Schaeffer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 July 1945 at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 July 1945 to 3 July 1945and that I last saw her alive on 3 July 1945

Immediate cause of death

abdominal hemorrhageDue to Ruptured ectopic preg.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Josephine M. Schaeffer M. D. or otherAddress Fredericktown Date signed 3 July 45

RECEIVED
JUL 12 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 50.

1. PLACE OF DEATH:

County CabotCity or town Solomons
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CabotCity or town Solomons
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war 70

3. (a) FULL NAME

Leon Luchy

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 6, 1904

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

41216

hrs.

min.

9. Birthplace

Chicot, Ind
(Town, county, and state)

10. Usual occupation

Guard (Mine Harbor)

11. Industry or business

Treat Station Solomons

FATHER

12. Name

Everett H. Luchy

13. Birthplace

Cabot Co., Md

MOTHER

14. Maiden name

Eliza E. Readmond

15. Birthplace

St. Mary's Co., Ind

16. Informant

Gray Luchy

Address

Solomons, Ind

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 24, 1945
(month) (day) (year)

Cemetery or crematory

Solomons M.E.

Location

Solomons, Ind.

18. Funeral director

A. A. Harkness & Son

Address

Mutual, Ind.

19.

(Date reg'd by registrar)

July 24, 45 - A. E. Foster

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1945 to July 1945and that I last saw him alive on July 22, 1945

Immediate cause of death

Cancer of prostate

DURATION

9 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Prize C. Foster

M. D. or other

Address Prize Frederick Date signed July 24, 1945

RECEIVED
AUG 22 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

06835

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Owing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CalvertCity or town Owing
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George William Owing

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife

Ida Owing6. (c) If alive, give age 71 years

7. Birth date of

deceased (mo., day, yr.) March 22 1871

8. AGE:

Years

Months

Days

If less than one day

74328

hrs.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Thomas Owing

13. Birthplace

MD

14. Maiden name

Ellen Carpenter

15. Birthplace

Missouri

16. Informant

Wm. Edith Peaty

Address

Owing MD

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 22 - 45
(month) (day) (year)

Cemetery or crematory

Friendship Cemetery

Location

Friendship, A.A.C., Md.

18. Funeral director

W. H. Hutchins

Address

Owings, Md

19.

(Date rec'd by registrar)

19 45Grace Hutchins
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20 1945, at 6:02 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14 1945, to 7/20 1945and that I last saw him alive on 7/19 1945

Immediate cause of death

arteriosclerosis
acute

DURATION

2 yrs
13 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hugh W Ward

M. D. or other

Address

Owing, MDDate signed 7/20/45

RECEIVED
AUG 14 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *183*

CERTIFICATE OF DEATH

Reg. Dist. No. *52*

1. PLACE OF DEATH:

County *Baltimore*City or town *N. Beach*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles C. Sellers

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Oct. 23, 1884

8. AGE:

Years

61

Months

Days

If less than one day

hrs.

min.

9. Birthplace

South Carolina

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Charles C. Sellers

Address

1025 North Filmore Ave

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof *July 9, 1945*
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

Washington Va

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Virginia* CountyCity or town *Arden*
(If outside city or town limits, write RURAL and give nearest town)

Street No.

1131 North Guncy Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/8 19 *45* at *12:10 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him alive on

..... 19.....

Immediate cause of death

Drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Arden
(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Drown

Injured at work?

23. SIGNATURE

Hugh W. Ward
M. D. or other

Address

Arden Date signed *7/8/45*

RECEIVED

AUG 14 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

CERTIFICATE OF DEATH

★ Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Dunkirk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County CalvertCity or town Dunkirk
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Leslie H. Young

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Feb. 7 1889

8. AGE:

Years 56Months 5

Days

If less than one day

hrs.

min.

9. Birthplace

Calvert Co.
(Town, county, and state)

10. Usual occupation

H. H. Labor

11. Industry or business

MOTHER FATHER

12. Name

James Peel

13. Birthplace

Calvert

14. Maiden name

Margaret Young

15. Birthplace

Calvert

16. Informant

Sadie Wilson

Address

Dunkirk, Ind.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 10 1945
(month) (day) (year)

Cemetery or crematory

Hall's Creek

Location

Dunkirk, Ind.

18. Funeral director

W. B. Johnson

Address

Annapolis

19. July 8

(Date read by registrar)

19. 45

Trace Hatchins

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19____, to 19____

and that I last saw h. i.m. alive on 1945

Immediate cause of death

Pneumonia

DURATION

Due to

Ca of lung -

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? +

23. SIGNATURE

P. C. Lett VILLAR, CAL

M. D. or other

Address Prine Frederick Date signed 7/8/45

RECEIVED
JUL 21 1945
BUREAU V. S.